Small Group Health Insurance Reform In New Hampshire

Report to Joint Committee on Health Care Oversight
February 2006

Christopher F. Koller
Health Insurance Commissioner

REPORT TO THE LEGISLATURE

FROM THE HEALTH INSURANCE COMMISSIONER

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Executive Summary

This report focuses on the small group health insurance market and efforts to strike a regulatory balance for that market in New Hampshire. In New Hampshire, as in all states, the policy goal for the small group market is to preserve access to affordable coverage for as many groups as possible. The challenge is to make coverage affordable to high-risk groups (which involves spreading costs to lower-risk groups) while keeping coverage affordable for low-risk groups as well, so that they will continue to participate in the market. It can be a further challenge to maintain participation from insurance carriers in this market while imposing fair "rules of the game." New Hampshire has wrestled with both of these issues.

In 1994, in response to concerns about access to, and fairness in rating of, health insurance for small employer groups, the New Hampshire Legislature passed SB 711. The bill was consistent with legislation passed in many other states during that time period. It limited the extent to which insurers covering groups of 1-100 employees could either deny coverage to individuals or groups or vary rates within and across groups based on such factors as age, location, industry classification, and health status. The

effect of this law was to spread risks (and therefore costs) more broadly across both individuals and groups in the small group market, triggering rate increases for younger, healthier subscribers and rate decreases for older, less healthy subscribers.

By 2003 the New Hampshire legislature had become concerned that the reforms introduced under SB 711 might have gone too far in restricting health insurer practices, and in spreading costs to younger, healthier individuals and groups. Another consequence of the law was that a number of insurers had exited the New Hampshire market, as they saw it as less desirable for doing business.

The New Hampshire legislature responded with the passage in 2003 of SB 110, which re-introduced underwriting practices that had been prohibited since 1994 and reduced the scope of the earlier reforms to groups of 1-50. The effect of this law was to allow greater segregation of the insured market and less spreading of costs – older, less healthy groups and individuals saw dramatic rate increases, while younger, healthier individuals and groups saw rate reductions.

New Hampshire legislators once again became concerned with the effect of their reforms on variation in small group health insurance rates after passage of SB 110. While they had hoped to increase carrier participation in the New Hampshire market and thus increase competition, legislators saw the effect of SB 110 in terms of increases in rates paid by older, less healthy groups as unacceptable. As a result, they scaled back permissible underwriting practices again in 2005 through SB 125. However, they also

created a reinsurance mechanism to address carrier concerns about risk exposure in an environment that required guaranteed issue and greatly limited carrier rate flexibility. The reinsurance mechanisms allows for the costs of the highest-risk cases to be spread across all carriers.

SB 125 took effect on January 1, 2006. By combining strict regulation of underwriting and rate increases with a reinsurance mechanism for the small group market, New Hampshire policy-makers are hoping to stabilize rates for all consumers, minimize the burden of high-risk status on those who have it, and maintain a market that is attractive to an adequate number of insurance carriers to promote competition and consumer choice. It remains to be seen whether New Hampshire's most recent approach will successfully achieve those goals.

Background: striking a balance in the regulation of small group health insurance

In theory, health insurance is a mechanism to spread risk across a broad population to protect all who participate from an unpredictable event – a potential high cost illness or accident. In reality, however, health care costs are not as random as we might expect. Certain characteristics of individuals work as fairly good predictors of expected future health care utilization and insurance claims cost. Past and current health status is the best predictor. Age, gender, occupation and geographic location also relate, on average, to health care costs.

Insurers have figured out that they can use predictors of health care costs to protect themselves against risk, thereby having a more profitable and more predictable business. Insurers historically have used two methods to protect themselves: 1. they refuse coverage to individuals or groups who are determined to be "bad risks," meaning they are likely to have high future health care costs, and; 2. they charge higher rates to people who are bad risks, so that the insurer either is assured of having the costs covered or discourages bad risks from enrolling. The process of estimating what to charge and setting higher premiums based on experience or characteristics is called underwriting.

States, meanwhile, as the primary regulators of health insurance, have learned that risk avoidance on the part of insurers can lead to insurance market failure. State policy-makers worry that those who need health insurance the most will no be able to obtain it. If bad risks are excluded from or priced out of the market, they are left uninsured.

States therefore have used two methods to counterbalance insurer underwriting behavior: 1. they have required guaranteed issue, meaning that insurers must "take all comers" and can not deny coverage to high risk individuals or groups, and; 2. they have placed limits on the extent to which, and the factors upon which, insurers can vary rates across their covered population. During the 1990s, most states adopted laws that restricted the extent to which insurers could refuse coverage based on an individual's health status or health history. In 1996 Congress passed the Health Insurance Portability and Accountability Act (HIPAA), which imposed some standardization on these state requirements for small employer groups (groups of 2-50 employees). Most states also have imposed rating

restrictions on insurers, but those restrictions are not part of HIPAA and continue to vary state-to-state. Some states have taken a very restrictive approach, requiring that costs be spread fairly evenly across all insured people. Other states have allowed insurers to charge considerably higher rates to those who are predicted to be "high-risk."

The issue of how much to restrict insurer underwriting practices is made more complicated for states by the fact that insured individuals and groups can choose not to participate in the insurance market. Individuals and groups can choose to be uninsured, and groups can, in some cases, choose to self-insure. This means that the balancing act related to shifting costs from healthy to unhealthy people relates not only to concepts of fairness, but also to incentives to stay in the market. If too much cost is shifted to healthy individuals and groups, they will not stay in the market, and the market will collapse without any good risks. Additionally, not all insurance carriers will participate in a market that does not allow for risk differentiation among insureds. If policy-makers desire an insurance market with a large number of participating carriers, strict regulation might impede that goal.

This report focuses on the small group health insurance market and efforts to strike a regulatory balance for that market in New Hampshire. In New Hampshire, as in all states, the policy goal for the group market is to preserve access to affordable coverage for high-risk groups while avoiding pushing low-risk groups out of the market. At the same time, policy-makers have tried to minimize the differences between the rules governing the small group market and contiguous markets so as to avoid adverse

selection against the regulated market. New Hampshire has wrestled with finding the right balance between regulation and competition in this market and the state's efforts in that regard since 1994 are described here.

The New Hampshire experience

In 1994, in response to concerns about access to, and fairness in rating of, health insurance for small employer groups, the New Hampshire Legislature passed SB 711. The bill was consistent with legislation passed in many other states during that time period, and required, for employer groups with 1-100 employees:

- Guaranteed issue: no group could be denied insurance from any insurer selling in the small group market.
- Guaranteed renewability: once a health policy was purchased, the insurer was generally required to renew the policy at the option of the insured.
- Portability: Anyone with a preexisting condition who changed employers and therefore insurers would have his or her period of coverage with the previous carrier applied as a credit against the succeeding carrier's preexisting condition exclusion period.
- Limitations on preexisting condition exclusion periods: benefits had to be provided for all preexisting conditions for an insured whose policy had been in effect for at least nine months.

In addition, insurers were allowed to use only two rating factors to differentiate prices between employer groups under SB 711. These were:

- Age: groups were rated up or down from an average or "community" rate based on the age of employees. The maximum variation allowed under the age rating factor was three to one. That is, the rate for the highest rated group based on age could not exceed the rate of the lowest rated group by more than 300 percent.
- Size of group: Groups were rated up or down from a community rate based on the size of the group with a maximum permissible variation of 1.2 to 1 or 20 percent.

Prior to the passage of SB 711, premiums charged to small employer groups could vary significantly based on the age, location, industry classification, and health status of a group.

By 2003 the New Hampshire legislature had become concerned that the reforms introduced under SB 711 might have gone too far in restricting health insurer practices, with the consequence being that a number of insurers had exited the New Hampshire market, and individuals and groups who were classified as lower risks had seen significant rate increases.

The result was the passage in 2003 of SB 110, which re-introduced underwriting practices that had been prohibited since 1994. Under SB 110:

- The definition of small group was changed from 1-100 to 1-50. This meant that requirements for guaranteed issue, guaranteed renewability, portability and limits on preexisting condition exclusion periods no longer applied to groups of 50-100 employees.
- The rating factor for age was changed from 3:1 to 4:1.
- A rating factor for geographic location was introduced and allowed for a 1.15 to 1 or 15 percent differential in rates.
- A rating factor for industry classification was introduced and allowed for a 1.2 to 1 or 20 percent differential in rates.
- A rating factor for health status was introduced and allowed for a 1.67 to 1 or 67 percent differential in rates, and insurers were allowed to use previously-prohibited individual health statements for rating purposes.
- A rating factor was introduced that allowed insurers to rate up groups of one (self-employed individuals) by 10 percent.

The combined effect of the existing rating factors and the new rating factors introduced by SB 110 resulted in a permissible rate variation between the highest and the lowest rated groups of 12.2 to 1. Prior to SB 110, the maximum permissible variation was less than 3.6 to 1. In allowing for increased variation, SB 110 substantially changed the distribution of insurance premiums among the employers in the small group market. Generally, smaller groups that had older and sicker employees paid more and larger groups with younger and healthier employees paid less.

SB 110 also included limitations on the premium increases that small groups could experience at annual renewal. Increases solely attributable to changes in health status were limited to 15 percent. During a transition period that ended January 1, 2005, increases that were solely attributable to the combined effect of health status, geographic location, industry classification and self-employed status were limited to 25 percent.

New Hampshire legislators again became concerned with the effect of their reforms on variation in small group health insurance rates after passage of SB 110. While they had hoped to increase carrier participation in the New Hampshire market and thus increase competition, no such increase had occurred. In addition, legislators saw the effect of SB 110 in terms of increases in rates paid by older, less healthy groups as unacceptable. Some groups received rate increases of more than 100 percent when SB 100 went into effect. As a result of these concerns, the legislature again scaled back permissible underwriting practices in 2005 through SB 125. SB 125:

- Set a "composite rate band" of 3.5 to 1. This means that the highest premium charged by a carrier for a particular type of coverage cannot be more than 3.5 times greater than the lowest premium charged for that coverage.

- Disallowed the rating factor for groups of one, meaning that self-employed individuals could not be charged a higher premium based on that status.

- Restricted rating factors to age, group size and type of industry. A carrier may not vary rates based on health status, gender, geographic location, or any other characteristic of a group or the employees in that group.

A comparison of the premium rate derivations under SB 110 and SB 125 appears in figure 1. As the figure illustrates, SB 125 allows for greater variation in rates during a transition period.

Figure 1

Premium rate derivation, small group market
New Hampshire and Rhode Island Compared

Rating factors	NH under SB 110 (2003-2005)			NH under SB 125 (beginning Jan. 1, 2006)			Rhode Island - Prevailing		
	Min	Max	Ratio	Min	Max	Ratio	Min	Max	Ratio
Health	0.85	1.42	1.67	NA	NA	NA	0.92	1.10	1.21
Age	0.75	2.25	3.00	0.60	3.15	5.25			
Age and Health combined							0.40	1.60	4.00
Group size	0.90	1.08	1.20	0.90	1.19	1.32	NA	NA	NA
Group size of one	1.00	1.10	1.10	NA	NA	NA	NA	NA	NA
Industry	0.95	1.14	1.20	0.95	1.14	1.20	NA	NA	NA
Geographic location	0.95	1.09	1.15	NA	NA	NA	NA	NA	NA
Interim (transitional) total				0.51	4.27	8.33			
Total	0.52	4.73	9.13	0.92	3.20	3.50	0.40	1.60	4.00

NA = use of this rating factor not allowed
Rhode Island: Allows rating by age, sex with small risk adjustment factor (± 104.). Ratios shown are based on Interim 2006 Market Conduct findings.

SB 125 also capped premium increases for the small group market at 20 percent plus trend. This means that a group's premium at renewal may not increase more than 20 percent in excess of medical inflation unless the members of that group have changed or the group purchases different coverage.

Lastly, SB 125 created a reinsurance mechanism through which carriers can cede the risk (meaning transfer responsibility to the state) of high-risk employees or groups. The state's goal, in creating this mechanism, was to address carrier concerns about risk exposure in an environment that required guaranteed issue and greatly limited carrier rate flexibility. In doing so, lawmakers hoped to enhance stability in the small group market and remove barriers to entry for carriers wishing to do business in the state. The reinsurance mechanism is funded through an assessment on all carriers participating in the small group market, based on their covered lives, plus direct payments from carriers that cede employees or groups to the reinsurance mechanism. If an employee or group is ceded to the reinsurance mechanism, neither the employee nor the group is made aware of this. The carrier simply becomes eligible for reimbursement of some claims through the reinsurance mechanism.

The New Hampshire reinsurance mechanism should not be confused with a high-risk pool. It differs from a high-risk pool in two important ways. First, the insured high risk individual sees no difference in the coverage as a result of being deemed "high risk." With a high-risk pool, that person would actually enroll in a separate pool and likely receive different coverage than others in the employee group. Second, the insurer does

not entirely escape responsibility for the risk associated with less healthy individuals under the New Hampshire reinsurance mechanism. Rather, the costs associated with these individuals are spread across all carriers in proportion to their volume of business in the state. The New Hampshire approach also differs from the approach taken in New York state, where reinsurance is used as a mechanism to reduce premium costs for high-risk groups that have been excluded from the market.

The standardized health statement (a questionnaire to be filled out by all enrollees) has been reintroduced to the New Hampshire market to support the identification of enrollees who might be high-risk and therefore might be assigned to the reinsurance mechanism. A copy of the standardized health statement is provided in appendix A. Carriers must make the decision to cede an individual or group within 60 days of issue of a policy covering that group. If the carrier makes the decision to cede, they will pay a fee to the reinsurance mechanism that exceeds the premium paid by the individual or group.

SB 125 went into effect on January 1, 2006. The New Hampshire insurance department has organized the governing board for the reinsurance mechanism, which includes representatives of carriers, and that board approved an operation and procedures manual in December, 2005. The board is expected to hire an independent administrator for the pool through a competitive bidding process. The board's manual describes the process a carrier must go through in order to cede a risk to the reinsurance pool. However, the methodology for determining the rates paid by carriers to the pool has yet to be

developed by the board. A copy of the operation and procedures manual is provided in appendix B.

Effect of changes on the insurance market and employer groups

The overall effect of the changes in New Hampshire's insurance laws during the period 1994 to 2005 appears to be one of consolidating the state's insurance market. In 1994, there were 26 small group carriers operating in the state with significant market participation. In 2005, there were five. The effect on employer groups, however, was less dramatic than this market consolidation might suggest. The business in New Hampshire's small group insurance market has been very concentrated throughout this period with the two largest carriers accounting for 72 percent of market share in 1994 and 73 percent of market share in 2000. Therefore, while a number of carriers exited the state after the passage of the 1994 reforms, few consumers were affected by that exit. Figure 2 below illustrates this point. According to staff of the New Hampshire Insurance Department, passage of SB 125 has not caused additional carriers to leave the state.

Figure 2

Number of carriers in NH small group health insurance market with significant* market participation, and market share of the two carriers with the largest market share

	1994 (prior to SB 711)	**2001 (after passage of SB 711, before SB 110)**	**2002 (most recent available data)**
Number of small group carriers	26	9	5
Percent market share, two largest carriers	72%	75%	73%

*greater than 5%

Sources: Kenyon, 2003 and New Hampshire Insurance Department, 2006; New Hampshire Insurance Department, Supplemental Report of the 2002 Insurance Market.

Summary

In striking a balance between protecting high-risk consumers from being excluded from or priced out of the health insurance market, on the one hand, and maintaining participation in the market from both low-risk individuals and insurance carriers, on the other, New Hampshire public policy has swung from one extreme to the other. In 1994 legislators enacted tighter regulation of health insurer rating practices in response to concerns about fairness in the market (both in terms of some individuals and groups paying much higher premiums than others, and in terms of some carriers "cherry-

picking" the market for good risks). Tighter regulation in the 1990s had the following effects:

- Some carriers left the state
- Some younger and healthier (on average) groups paid higher premiums than they would have under previous law, while some older and less healthy groups paid lower premiums

When New Hampshire legislators became concerned that the tighter regulation had gone too far, they relaxed regulation in 2003 and the result was that some older and less healthy groups (on average) paid much higher premiums than they would have under previous law, while some younger and healthier paid much lower premiums.

In response to concern about the rate changes experienced under the 2003 law, and expected future increases, lawmakers have now tried a third approach. By combining strict regulation of underwriting and rate increases with a reinsurance mechanism for the small group market, New Hampshire policy-makers are hoping to stabilize rates for all consumers, minimize the burden of high-risk status on those who have it, and maintain a market that is attractive to an adequate number of insurance carriers to promote competition and consumer choice. It remains to be seen what the effect of this third approach will be, and whether the state will achieve its policy goals.

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Report prepared with assistance from Anya Rader Wallack,
Consultant to the Office of the Health Insurance Commissioner
401-222-5424